Initial Contact Form

1. Last Name: *

5. Form Date: *

6. Worker: *

2. First Name: *

3. Other Name: (e.g., maiden)

4. Birth Date: *

7. Lives in target area?

- ◯ Yes
- ◯ No
- ◯ Unknown

8. Primary Language:

- ◯ English
- ◯ Spanish
- ◯ Other:

9. Would you like to become pregnant in the next year?

- ◯ Yes
- ◯ No
- ◯ Unsure

Demographics Optional. As reported by client.

10. Gender:

- ◯ Female
- ◯ Male
- ◯ Non-binary

11. Ethnicity:

- ◯ Hispanic/Latinx
- ◯ Not Hispanic/Latinx
- ◯ Declined to self-identify

12. Race: (Check all that apply)

- ☐ White
- ☐ Black/African-American
- ☐ Asian
- ☐ Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Declined to self-identify
- ☐ Unknown
- ☐ Other:

13a. Type of referral/recruitment source:

- ◯ Outreach (Street / Door-to-Door)
- ◯ Outside Referral to MICHC
- ◯ Group Session Attendance
- ◯ Unrecorded
- ◯ Other:

13b. If street outreach, specify location:

13c. Outside Referrer:

- ◯ Prenatal Care Provider
- ◯ Primary Care Physician
- ◯ Dental Provider
- ◯ Pediatrician
- ◯ Birthing Hospital
- ◯ Family Planning Provider
- ◯ Health Home
- ◯ Mental Health / Behavioral Health
- ◯ Other Health Care Provider, Specify:
- ◯ Social Service Agency
- ◯ WIC
- ◯ Public Health Nurse / LHD
- ◯ School
- ◯ Insurance Navigator
- ◯ Managed Care Plan
- ◯ Community - Based Organization
- ◯ Faith - Based Organization
- ◯ Relative / Friend
- ◯ Other MICHC Program
- ◯ Other Client

- ○ Self
- ○ Other Service, Specify: ______

14. Primary Presenting Need:

______

15. Action Taken: (Check all that apply)

- ☐ Provided information and/or referral
  (complete Encounter Form and fill out Referrals)
- ☐ Completed Screening Assessment
  (continue to and complete Screening Assessment Form)
- ☐ Will schedule follow-up for Screening Assessment
  (complete Screening Assessment Form at a later date)

Screening/Assessment Form

Client Name:

1. Intake Date: *

2. Worker: *

3a. Living Arrangement:

- ◯ Lives alone or with child/children
- ◯ Lives with spouse/partner
- ◯ Lives with parent(s)
- ◯ Lives with partner's parent (s) or other related adults
- ◯ Lives with other unrelated adults
- ◯ Lives in foster/group home
- ◯ Homeless/no permanent residence
- ◯ Refused/Unknown
- ◯ Other:

3b. Is homeless or has no permanent residence?

- ◯ Yes
- ◯ No
- ◯ Unknown

4. Highest Grade Completed:

- ◯ Less than 8th
- ◯ 8-11
- ◯ High school graduate
- ◯ GED
- ◯ Vocational school after HS
- ◯ Some college
- ◯ Associates degree
- ◯ Bachelor's degree or higher

5. Currently enrolled in education/training program?

- ◯ Yes
- ◯ No
- ◯ Unknown

6a. Currently is working for pay?

- ◯ Yes
- ◯ No
- ◯ Unknown

6b. Current job is: (Check all that apply)

- ☐ Full-time
- ☐ Part-time
- ☐ Temporary

7. Receiving any of the following benefits?

(Check all that apply)

- ☐ TANF
- ☐ Emergency Assistance
- ☐ SSI/SSD
- ☐ Food stamps
- ☐ WIC

8. Total number of people in household:

9. Average total monthly income of household:

$

- ☐ Unknown

10. Average total monthly value of benefits:

$

- ☐ Unknown

11a. Usual source of medical care:

- ○ Doctor/clinician's office
- ○ Hospital outpatient clinic
- ○ Federally qualified health center (FQHC)
- ○ Emergency department
- ○ Urgent care
- ○ None
- ○ Unknown
- ○ Other:

11b. Had well-visit (non-sick visit) in the past year?

- ○ Yes
- ○ No
- ○ Unknown

12a. Currently has a dental provider?

- ○ Yes
- ○ No
- ○ Unknown

12b. Had dental visit in the past 6-8 months?

- ○ Yes
- ○ No
- ○ Unknown

12c. Has any dental problems?

- ○ Yes
- ○ No
- ○ Unknown

13a. Currently has health insurance coverage?

- ○ Yes
- ○ No
- ○ Unknown

13b. Type of health insurance:

(Check all that apply)

- ☐ Medicaid/Medicaid Managed Care
- ☐ Child Health Plus
- ☐ Private Insurance
- ☐ FPEP or FPBP (family planning only)
- ☐ Unknown
- ☐ Other:

Reproductive History

14. Number of previous pregnancies:

(Include current pregnancy, if applicable)

15. Date of last delivery: (if applicable)

16a. Number of previous live births:

16b. Any previous babies born below normal weight?

(Less than 5 lbs 8 oz)

- ◯ Yes
- ◯ No
- ◯ Unknown

16c. Any previous premature births?

(36 weeks or less)

- ◯ Yes
- ◯ No
- ◯ Unknown

16d. Any previous still births or fetal deaths?

- ◯ Yes
- ◯ No
- ◯ Unknown

17a. Currently pregnant? *

- ◯ Yes
- ◯ No
- ◯ Unknown

17b. If so, expected date of delivery:

18a. If not currently pregnant, would like to become pregnant in the next 12 months?

- ◯ Yes
- ◯ No
- ◯ Unknown
- ◯ Unsure

18b. If no, currently taking steps to prevent a pregnancy?

- ◯ Yes
- ◯ No
- ◯ Unknown

18c. If yes, types of birth control used:

(Check all that apply)

- ☐ Abstinence
- ☐ Birth control pill
- ☐ Cervical cap (FemCap)
- ☐ Female condom
- ☐ Spermicide
- ☐ Withdrawal/Other
- ☐ Birth control implant (Implanon/Nexplanon)
- ☐ Birth control vaginal ring (NuvaRing)
- ☐ Condom
- ☐ Emergency contraception (morning after pill)
- ☐ Tubal ligation (female sterilization)
- ☐ Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- ☐ Birth control patch (Ortho Evra)
- ☐ Birth control shot (Depo-Provera)
- ☐ Diaphragm
- ☐ IUD (Mirena, Paragard)
- ☐ Vasectomy (male sterilization)

General Health & Well-Being

19. Taking folic acid supplements?

(Or prenatal vitamins, if pregnant)

- ◯ Yes
- ◯ No
- ◯ Unknown

20. Any concerns about a healthy weight?

- ◯ Yes
- ◯ No
- ◯ Unknown

21a. Does potential client use tobacco products or vapes?

- ◯ Yes
- ◯ No
- ◯ Unknown

21b. Does anyone in the household use tobacco productst or vapes?

- ◯ Yes
- ◯ No
- ◯ Unknown

22a. Have they traveled recently (approx. past 3-6 months)?

- ◯ Yes
- ◯ No
- ◯ Unknown

22b. If yes, where?

Currently Pregnant Client

23a. Any prenatal visits?

- ◯ Yes
- ◯ No
- ◯ Unknown

23b. If yes, date of first prenatal visit:

23c. Number of prenatal visits:

24. Plan to feed with breast milk?

- ◯ Yes
- ◯ No
- ◯ Unknown

25a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

25b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

26. Has physician indicated any concerns about pregnancy weight gain?

- ◯ Yes
- ◯ No
- ◯ Unknown

27a. Has physician indicated any other concerns about pregnancy?

- ◯ Yes
- ◯ No
- ◯ Unknown

27b. If yes, specify physician's concerns:

28. Selected a method of birth control to discuss with physician?

- ◯ Yes
- ◯ No

Client with Children Under Twelve Months

29. Does baby have health insurance?

- ◯ Yes
- ◯ No
- ◯ Unknown

30. Does baby have a primary medical provider?

- ◯ Yes
- ◯ No
- ◯ Unknown

31. Child(ren)'s usual source of medical care:

- ◯ Doctor/clinician's office
- ◯ Hospital outpatient clinic
- ◯ Federally qualified health center (FQHC)
- ◯ Emergency department
- ◯ Urgent care
- ◯ None
- ◯ Unknown
- ◯ Other: ______

32. Currently feeding with breast milk?

- ◯ Breast milk only
- ◯ Breastmilk and formula/solids
- ◯ No

33a. Was child ever fed breast milk?

- ◯ Yes
- ◯ No
- ◯ Unknown

33b. If yes, number of months fed breast milk:

______ Months

33c. Number of months fed only breast milk:

______ Months

34a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other: ______

34b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other: ______

35. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
On Back	◯	◯	◯	◯

35. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
Alone	○	○	○	○
In Crib	○	○	○	○

Alcohol Use (AUDIT-C)

36. How often do you have a drink containing alcohol?

- ○ Never (0)
- ○ Monthly or less (1)
- ○ 2-4 times a month (2)
- ○ 2-3 times a week (3)
- ○ 4 or more times a week (4)

37. How many standard drinks containing alcohol do you have on a typical day?

- ○ 2 or less (0)
- ○ 3 or 4 (1)
- ○ 5 or 6 (2)
- ○ 7 to 9 (3)
- ○ 10 or more (4)

38. How often do you have six or more drinks on one occasion?

- ○ Never (0)
- ○ Less than monthly (1)
- ○ Monthly (2)
- ○ Weekly (3)
- ○ Daily or almost daily (4)

39. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

40. Was client referred?

- ○ Yes
- ○ No

41. If another evidence based screening tool was used, what was it?

Substance Abuse (NIDA)

42. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	○	○	○	○	○
Tobacco Products	○	○	○	○	○

42. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Prescription Drugs for Non-Medical Reasons	○	○	○	○	○
Illegal Drugs	○	○	○	○	○

43. In your lifetime, which of the following substances have you ever used?

- ☐ Cannabis
- ☐ Cocaine
- ☐ Prescription stimulants
- ☐ Methamphetamine
- ☐ Inhalants
- ☐ Sedatives or sleeping pills
- ☐ Hallucinogens
- ☐ Street opioids
- ☐ Prescription opioids
- ☐ Other: ________

44. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

45. Was client referred?

- ○ Yes
- ○ No

46. If another evidence based screening tool was used, what was it?

Domestic Violence (HITS)

47. How often does your partner...?	**Not at all** *Score 1*	**Rarely** *Score 2*	**Sometimes** *Score 3*	**Fairly often** *Score 4*	**Frequently** *Score 5*
Physically hurt you	◯	◯	◯	◯	◯
Talk down to you	◯	◯	◯	◯	◯
Threaten you with harm	◯	◯	◯	◯	◯
Scream or curse at you	◯	◯	◯	◯	◯

48. If any of the above items are not answered, why?

◯ Does not want to disclose
◯ Safety concerns
◯ No partner
◯ Other:

49. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

◯ Yes
◯ No

50. Screening Result?

◯ Positive
◯ Negative
◯ Refused

51. Was client referred?

◯ Yes
◯ No

52. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

53. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Little interest or pleasure in doing things	◯	◯	◯	◯

53. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Feeling down, depressed, or hopeless	◯	◯	◯	◯
Trouble falling asleep or staying asleep, or sleeping too much	◯	◯	◯	◯
Feeling tired or having little energy	◯	◯	◯	◯
Poor appetite or overeating	◯	◯	◯	◯
Feeling bad about yourself - or that you are a failure or have let your family down	◯	◯	◯	◯
Trouble concentrating on things, such as reading the newspaper or watching TV	◯	◯	◯	◯
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	◯	◯	◯	◯
Thought that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯

54. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

55. Screening Result?

- ◯ Positive
- ◯ Negative
- ◯ Refused

56. Was client referred?

- ◯ Yes
- ◯ No

57. If another evidence based screening tool was used, what was it?

Issues

58. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Substance use	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Physical disability/health problems	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Depression	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Other mental illness/disability	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Domestic violence	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Marital or relationship difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

58. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Health concerns for yourself	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Financial difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Unemployment (self or partner)	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Homelessness/inadequate housing	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Legal problems	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Social isolation	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Stress or emotional difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

58. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Inadequate food, clothing, or household items	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Smoking	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Problems with teeth or gums (e.g. pain, bleeding)	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Parenting	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Prenatal/postpartum health issues	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Health concerns for your child	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Concerns about your child's development	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

58. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Accessing dental care	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Information

59. Would like more information about...?
(Check all that apply)

- ☐ Family planning/contraception
- ☐ Pregnancy testing
- ☐ Safe sex
- ☐ Exercise, opportunities to exercise
- ☐ Nutrition, access to healthy foods
- ☐ HIV testing
- ☐ STD testing
- ☐ Job search/placement assistance
- ☐ Adult basic education or GED preparation
- ☐ ESL (English as a Second Language)
- ☐ Vocational or job skills training
- ☐ Alcohol
- ☐ Basic needs (housing, food, etc)
- ☐ Depression
- ☐ Domestic Violence
- ☐ Health Insurance
- ☐ Illicit Drug Use
- ☐ Preventative Care / Primary Care
- ☐ Smoking

Pregnant or Parenting

- ☐ Child care programs
- ☐ Parenting skills
- ☐ Lead assessment/testing
- ☐ Child development
- ☐ Safe sleep
- ☐ Environmental health/safety
- ☐ Car seat use
- ☐ Healthy pregnancy
- ☐ Feeding with breast milk and child nutrition
- ☐ Immunizations
- ☐ Accessing dental care
- ☐ Birth Plan / Preterm Birth
- ☐ Infant / New Born Care
- ☐ Postpartum Care
- ☐ Prental Care

Child Information & Pregnancy Outcomes Form

Client Name:

1. Form Date: *

2. Worker: *

Pregnancy

3a. Did birthing person/client receive prenatal care?

- ○ Yes
- ○ No
- ○ Unknown

3b. Date began receiving prenatal care?

- ☐ Unknown

4. Did birthing person/client visit dentist during pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

5. Did birthing person/client smoke during pregnancy?

- ○ Yes
- ○ No
- ○ Unknown

6. Number of births:

Children

7. Last Name: *

8. First Name: *

9. Birth Date: *

10. First Birth?

- ◯ Yes
- ◯ No

11. Gestational Age: (In whole weeks)

Weeks

12. Birth Weight:

Lbs Oz

13. Was a live birth?

- ◯ Yes
- ◯ No

14. Type of Delivery:

- ◯ Vaginal
- ◯ Cesarean

15. Was in an intensive care unit?

- ◯ Yes
- ◯ No

16. Was infant alive at hospital discharge?

- ◯ Yes
- ◯ No

17. Was infant receiving breast milk at discharge?

- ◯ Yes
- ◯ No

18. Gender:

- ◯ Female
- ◯ Male
- ◯ Non-binary

19. Ethnicity:

- ◯ Hispanic/Latinx
- ◯ Not Hispanic/Latinx
- ◯ Declined to self-identify

20. Race: (Check all that apply)

- ☐ White
- ☐ Black/African-American
- ☐ Asian
- ☐ Pacific Islander
- ☐ American Indian/Alaska Native
- ☐ Declined to self-identify
- ☐ Unknown
- ☐ Other:

21. Date of death (if applicable):

* Children missing required fields will not be saved.

Medical

22a. Has Insurance Coverage?

- ◯ Yes
- ◯ No
- ◯ Unknown

22b. Insurance Type:

(Check all that apply)

- ☐ Medicaid/Medicaid Managed Care
- ☐ Child Health Plus
- ☐ Private Insurance
- ☐ Unknown
- ☐ Other:

23. Post-partum visit scheduled?

- ◯ Yes
- ◯ No
- ◯ Unknown

24. Has birthing person/client selected a contraceptive method to discuss with their doctor?

- ◯ Yes
- ◯ No
- ◯ Unknown

ASQ Form

1. Infant: *

2. Worker: *

3. Date: *

4. Interval:

- ◯ 2 Months
- ◯ 4 Months
- ◯ 6 Months
- ◯ 9 Months
- ◯ 12 Months
- ◯ 18 Months
- ◯ at least 18 Months under 24 Months
- ◯ at least 24 Months under 36 Months
- ◯ at least 36 Months under 48 Months
- ◯ at least 48 Months under 60 Months

5. Infant is currently receiving services:

- ◯ Yes
- ◯ No

6. Parent declined further screening:

- ◯ Yes
- ◯ No

7. Was a referral made?:

- ◯ Yes
- ◯ No

8. Referral not needed at this time:

- ◯ Yes
- ◯ No

9. Monitoring prior to referral:

- ◯ Yes
- ◯ No

10. If another evidence based screening tool was used, what was it?

Communication:

Gross Motor:

Fine Motor:

Problem Solving:

Personal / Social:

Encounter Form

Client Name:

1. Encounter Date: *

2. Worker: *

3. Length of Visit:

Hrs Mins

4a. Type of Contact:

- ◯ In-person
- ◯ Phone
- ◯ E-mail
- ◯ Text
- ◯ Videoconferencing

4b. If in-person, where did it occur?

- ◯ Client home
- ◯ Other:

5. Who was present at visit?

(Check all that apply)

- ☐ Client
- ☐ Client's partner
- ☐ Client's parent(s)
- ☐ Client's child(ren)
- ☐ Other:

Activities (Check all that apply)

Health Care:

- ☐ Provide general health information
- ☐ Provide family planning/optimal birth spacing info
- ☐ Provide child health information
- ☐ Provide dental health information
- ☐ Provide nutrition/food preparation information

Family Functioning:

- ☐ Address issues re: violence in the home
- ☐ Discuss family relations
- ☐ Discuss substance use issues
- ☐ Discuss mental health issues
- ☐ Teach, foster communication skills

Concrete Activities:

- [ ] Provide safe sex or STD information
- [ ] Provide information of health providers or services
- [ ] Provide advocacy/support or accompany to medical providers and services
- [ ] Provide information on smoking cessation
- [ ] Completed / Reviewed Birth Plan

Prenatal/New Parent:

- [ ] Provide education/info re: prenatal care/pregnancy
- [ ] Discuss feelings about baby
- [ ] Provide labor and delivery support
- [ ] Address infant basic care needs (sleeping, bathing, etc)
- [ ] Provide safe sleep information
- [ ] Provide infant feeding information and support
- [ ] Provide breastfeeding information and support
- [ ] Provide information/equipment relating to child safety (car seats, child proofing homes, etc.)
- [ ] Discuss alcohol impacts during pregnancy
- [ ] Discuss Shaken Baby Syndrome
- [ ] Provide support to parents re: stresses of parenting
- [ ] Infant weight check
- [ ] Car seat check
- [ ] Crib check/crib for kids

Self-Sufficiency:

- [ ] Teach to use public transportation or provide maps or directions
- [ ] Teach how to use calendar or appointment book
- [ ] Address needs for child care
- [ ] Arrange for transportation
- [ ] Provide or arrange for food, clothes, diapers, or household goods
- [ ] Address legal needs
- [ ] Provide info and/or assistance with housing
- [ ] Translation
- [ ] Provide advocacy/support and/or accompany to non-medical providers or services
- [ ] Discuss child support issues
- [ ] Discuss visitation issues
- [ ] Discuss parental rights issues
- [ ] Arrange appointment for health care services

Program Activities:

- [ ] Complete forms
- [ ] Assess needs, develop or review family service plan

Crisis Intervention:

- [ ] Help resolve problems and handle crises

Other Activities:

- [ ] Other: ______

Client Medical Visits

Type of Visit *	Date of Visit *	Reason for Visit	**Weeks Pregnant** (if applicable)
Specify:			
Specify:			
Specify:			
Specify:			
Specify:			

* Records missing required fields will not be saved.

Type of Visit Codes:

1. Annual OBGYN exam
2. Prenatal visit
3. Postpartum visit
4. Routine physical
5. Urgent Care
6. Dental visit

99. Other

Baby Medical Visits

Type of Visit *	Date of Visit *	Reason for Visit	Child's Age (in months)	Lead screening done at this visit?
Specify:				◯ Yes ◯ No ◯ Unknown
Specify:				◯ Yes ◯ No ◯ Unknown
Specify:				◯ Yes ◯ No ◯ Unknown
Specify:				◯ Yes ◯ No ◯ Unknown
Specify:				◯ Yes ◯ No ◯ Unknown

* Records missing required fields will not be saved.

Type of Visit Codes:

1. Well-baby visit
2. Urgent Care
3. Non-well baby visit
4. Dental
99. Other

Baby Immunizations

Type of Immunization(s) *	**Date ***	**Child's Age** (in months)

* Records missing required fields will not be saved.

Type of Immunization Codes:

1. Hepatitis B
2. Rotavirus
3. Diphtheria, tetanus, & acellular pertussis
4. Haemophilus influenzae type b
5. Pneumococcal conjugate
6. Inactivated poliovirus
7. Influenza
8. Measles, mumps, rubella
9. Varicella
10. Hepatitis A
11. Meningococcal
12. Tetanus, diphtheria, & acellular pertussis
13. Human papillomavirus
14. Meningococcal B
15. Pneumococcal polysaccharide
16. COVID-19

Referrals

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	

* Records missing required fields will not be saved.

Service Codes:

Health Care
1. Adult primary care
2. Child primary care
3. Dental services
4. Early Intervention
5. Family Planning
6. Immunization

Home Visiting
28. Early Head Start
29. Head Start
30. Healthy Families New York
31. Healthy Start
32. Home Instruction for Parents of Preschool Youngsters

7. Lead Testing
8. Mental Health Services
9. Postpartum Care
10. Prenatal Care
11. Other, Specify

Family & Social Support Referrals

12. Breastfeeding
13. Car Seat
14. Childcare
15. Child Development
16. Child Support
17. Clothing / Baby Care Items
18. Domestic Violence
19. Educational Attainment
20. Employment / Vocational Services
21. Environmental Health / Safety
22. English as a Second Langauge (ESL)
23. Family Resource Center
24. Food Pantry
25. Furniture
26. Health Insurance
27. HEAP

33. Nurse-Family Partnership
34. Parent Child Home Program
35. Parents as Teachers
36. Public Health Nurse / LHD
37. Other Home Visiting Program, Specify

Other Services

38. Housing
39. Immigration Services
40. Legal Services
41. Nutrition, General
42. Safe Sleep
43. Smoking Cessation
44. SNAP (Food Stamps)
45. Substance Use
46. Support Groups
47. TANF/DSS Cash Assistance
48. Translation
49. Transportation
50. WIC
51. Other, Specify

Family Member Codes:

1. Client
2. Client's partner
3. Other biological parent of enrolled child (non-partner)
4. Enrolled child
5. Other child
6. Other relative
7. Non-relative

Update Form

Client Name:

1. Form Date: *

2. Worker: *

3a. Living Arrangement:

- ◯ Lives alone or with child/children
- ◯ Lives with spouse/partner
- ◯ Lives with parent(s)
- ◯ Lives with partner's parent (s) or other related adults
- ◯ Lives with other unrelated adults
- ◯ Lives in foster/group home
- ◯ Homeless/no permanent residence
- ◯ Refused/Unknown
- ◯ Other:

3b. Is homeless or has no permanent residence?

- ◯ Yes
- ◯ No
- ◯ Unknown

4a. Currently has health insurance coverage?

- ◯ Yes
- ◯ No
- ◯ Unknown

4b. Type of health insurance:

(Check all that apply)

- ☐ Medicaid/Medicaid Managed Care
- ☐ Child Health Plus
- ☐ Private Insurance
- ☐ FPEP or FPBP (family planning only)
- ☐ Unknown
- ☐ Other:

4c. Any period of no health insurance coverage since last update?

- ◯ Yes
- ◯ No
- ◯ Unknown

5. Receiving any of the following benefits?

(Check all that apply)

- ☐ TANF
- ☐ Emergency Assistance
- ☐ SSI/SSD
- ☐ Food stamps
- ☐ WIC

Reproductive History

6a. Been pregnant since last follow-up?

(Exclude pregnancy at program intake)

- ◯ Yes
- ◯ No
- ◯ Unknown

6b. If yes, currently pregnant?

*

- ◯ Yes
- ◯ No
- ◯ Unknown

6c. If so, expected date of delivery:

7a. If not currently pregnant, would like to become pregnant in the next 12 months?

- ◯ Yes
- ◯ No
- ◯ Unknown
- ◯ Unsure

7b. If no, have you been consistently using birth control since last follow-up?

- ◯ Yes
- ◯ No
- ◯ Unknown

7c. If yes, types of birth control used since the last follow-up:

(Check all that apply)

- ☐ Abstinence
- ☐ Birth control pill
- ☐ Cervical cap (FemCap)
- ☐ Female condom
- ☐ Spermicide
- ☐ Withdrawal/Other
- ☐ Birth control implant (Implanon/Nexplanon)
- ☐ Birth control vaginal ring (NuvaRing)
- ☐ Condom
- ☐ Emergency contraception (morning after pill)
- ☐ Tubal ligation (female sterilization)
- ☐ Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- ☐ Birth control patch (Ortho Evra)
- ☐ Birth control shot (Depo-Provera)
- ☐ Diaphragm
- ☐ IUD (Mirena, Paragard)
- ☐ Vasectomy (male sterilization)

General Health & Well Being

8. Taking folic acid supplements?

(Or prenatal vitamins, if pregnant)

- ◯ Yes
- ◯ No
- ◯ Unknown

9. Any concerns about a healthy weight?

- ◯ Yes
- ◯ No
- ◯ Unknown

10a. Does potential client use tobacco products or vapes?

- ◯ Yes
- ◯ No
- ◯ Unknown

10b. Does anyone in the household use tobacco productst or vapes?

- ◯ Yes
- ◯ No
- ◯ Unknown

11a. Have they traveled recently (approx. past 3-6 months)?

- ◯ Yes
- ◯ No
- ◯ Unknown

11b. If yes, where?

Currently Pregnant Client

12a. Any prenatal visits?

- ◯ Yes
- ◯ No
- ◯ Unknown

12b. If yes, date of first prenatal visit:

12c. Number of prenatal visits:

13. Plan to feed with breast milk?

- ◯ Yes
- ◯ No
- ◯ Unknown

14a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

14b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

15. Has physician indicated any concerns about pregnancy weight gain?

- ◯ Yes
- ◯ No
- ◯ Unknown

16a. Has physician indicated any other concerns about pregnancy?

- ◯ Yes
- ◯ No
- ◯ Unknown

16b. If yes, specify physician's concerns:

17. Selected a method of birth control to discuss with physician?

- ◯ Yes
- ◯ No

Client with Children Under Twelve Months

18. Does baby have health insurance?

- ◯ Yes
- ◯ No
- ◯ Unknown

19. Does baby have a primary medical provider?

- ◯ Yes
- ◯ No
- ◯ Unknown

20. Child(ren)'s usual source of medical care:

- ◯ Doctor/clinician's office
- ◯ Hospital outpatient clinic
- ◯ Federally qualified health center (FQHC)
- ◯ Emergency department
- ◯ Urgent care
- ◯ None
- ◯ Unknown
- ◯ Other: ______

21. Currently feeding with breast milk?

- ◯ Breast milk only
- ◯ Breastmilk and formula/solids
- ◯ No

22a. Was child ever fed breast milk?

- ◯ Yes
- ◯ No
- ◯ Unknown

22b. If yes, number of months fed breast milk:

______ Months

22c. Number of months fed only breast milk:

______ Months

23a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other: ______

23b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other: ______

24. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
On Back	◯	◯	◯	◯

24. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
Alone	○	○	○	○
In Crib	○	○	○	○

Alcohol Use (AUDIT-C)

25. How often do you have a drink containing alcohol?

- ◯ Never (0)
- ◯ Monthly or less (1)
- ◯ 2-4 times a month (2)
- ◯ 2-3 times a week (3)
- ◯ 4 or more times a week (4)

26. How many standard drinks containing alcohol do you have on a typical day?

- ◯ 2 or less (0)
- ◯ 3 or 4 (1)
- ◯ 5 or 6 (2)
- ◯ 7 to 9 (3)
- ◯ 10 or more (4)

27. How often do you have six or more drinks on one occasion?

- ◯ Never (0)
- ◯ Less than monthly (1)
- ◯ Monthly (2)
- ◯ Weekly (3)
- ◯ Daily or almost daily (4)

28. Screening Result?

- ◯ Positive
- ◯ Negative
- ◯ Refused

29. Was client referred?

- ◯ Yes
- ◯ No

30. If another evidence based screening tool was used, what was it?

Substance Abuse (NIDA)

31. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	◯	◯	◯	◯	◯
Tobacco Products	◯	◯	◯	◯	◯
Prescription Drugs for Non-Medical Reasons	◯	◯	◯	◯	◯
Illegal Drugs	◯	◯	◯	◯	◯

32. In your lifetime, which of the following substances have you ever used?

- ☐ Cannabis
- ☐ Cocaine
- ☐ Sedatives or sleeping pills
- ☐ Hallucinogens

33. Screening Result?

- ◯ Positive
- ◯ Negative

34. Was client referred?

- ◯ Yes
- ◯ No

- ☐ Prescription stimulants
- ☐ Methamphetamine
- ☐ Inhalants
- ☐ Street opioids
- ☐ Prescription opioids
- ☐ Other: ____
- ○ Refused

35. If another evidence based screening tool was used, what was it?

____

Domestic Violence (HITS)

36. How often does your partner...?	**Not at all** *Score 1*	**Rarely** *Score 2*	**Sometimes** *Score 3*	**Fairly often** *Score 4*	**Frequently** *Score 5*
Physically hurt you	○	○	○	○	○
Talk down to you	○	○	○	○	○
Threaten you with harm	○	○	○	○	○
Scream or curse at you	○	○	○	○	○

37. If any of the above items are not answered, why?

- ○ Does not want to disclose
- ○ Safety concerns
- ○ No partner
- ○ Other:

38. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

- ○ Yes
- ○ No

39. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

40. Was client referred?

- ○ Yes
- ○ No

41. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

42. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Little interest or pleasure in doing things	○	○	○	○

42. Over the last two weeks, how often have you been bothered by any of the following problems?	**Not at all** *Score 0*	**Several days** *Score 1*	**More than half the days** *Score 2*	**Nearly every day** *Score 3*
Feeling down, depressed, or hopeless	◯	◯	◯	◯
Trouble falling asleep or staying asleep, or sleeping too much	◯	◯	◯	◯
Feeling tired or having little energy	◯	◯	◯	◯
Poor appetite or overeating	◯	◯	◯	◯
Feeling bad about yourself - or that you are a failure or have let your family down	◯	◯	◯	◯
Trouble concentrating on things, such as reading the newspaper or watching TV	◯	◯	◯	◯
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	◯	◯	◯	◯
Thought that you would be better off dead or of hurting yourself in some way	◯	◯	◯	◯

43. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ◯ Not difficult at all
- ◯ Somewhat difficult
- ◯ Very difficult
- ◯ Extremely difficult

44. Screening Result?

- ◯ Positive
- ◯ Negative
- ◯ Refused

45. Was client referred?

- ◯ Yes
- ◯ No

46. If another evidence based screening tool was used, what was it?

Issues

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Substance use	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Physical disability/health problems	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Depression	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Other mental illness/disability	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Domestic violence	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Marital or relationship difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Health concerns for yourself	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Financial difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Unemployment (self or partner)	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Homelessness/inadequate housing	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Legal problems	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Social isolation	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Stress or emotional difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Inadequate food, clothing, or household items	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Smoking	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Problems with teeth or gums (e.g. pain, bleeding)	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Parenting	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Prenatal/postpartum health issues	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Health concerns for your child	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Concerns about your child's development	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Accessing dental care	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

Information

48. Would like more information about...?

(Check all that apply)

- ☐ Family planning/contraception
- ☐ Pregnancy testing
- ☐ Safe sex
- ☐ Exercise, opportunities to exercise
- ☐ Nutrition, access to healthy foods
- ☐ HIV testing
- ☐ STD testing
- ☐ Job search/placement assistance
- ☐ Adult basic education or GED preparation
- ☐ ESL (English as a Second Language)
- ☐ Vocational or job skills training
- ☐ Alcohol
- ☐ Basic needs (housing, food, etc)
- ☐ Depression
- ☐ Domestic Violence
- ☐ Health Insurance
- ☐ Illicit Drug Use
- ☐ Preventative Care / Primary Care
- ☐ Smoking

Pregnant or Parenting

- ☐ Child care programs
- ☐ Parenting skills
- ☐ Lead assessment/testing
- ☐ Child development
- ☐ Safe sleep
- ☐ Environmental health/safety
- ☐ Car seat use
- ☐ Healthy pregnancy
- ☐ Feeding with breast milk and child nutrition
- ☐ Immunizations
- ☐ Accessing dental care
- ☐ Birth Plan / Preterm Birth
- ☐ Infant / New Born Care
- ☐ Postpartum Care
- ☐ Prental Care

Discharge Form

Client Name:

1. Discharge Date: *

2. Worker: *

3. Discharge Reason:

- ◯ Client has met their goals
- ◯ Program unable to locate or make contact
- ◯ Participant non-compliant or unresponsive
- ◯ Participant refused
- ◯ Transferred/referred to another MICHC program
- ◯ Transferred/referred to a prevention/home visiting program
- ◯ Client deceased
- ◯ Client unavailable due to school or employment
- ◯ CHW left, client refused new CHW
- ◯ Safety issues for worker
- ◯ Program terminated due to mental health issues
- ◯ Family or other household member objects to program

4a. Living Arrangement:

- ◯ Lives alone or with child/children
- ◯ Lives with spouse/partner
- ◯ Lives with parent(s)
- ◯ Lives with partner's parent(s) or other related adults
- ◯ Lives with other unrelated adults
- ◯ Lives in foster/group home
- ◯ Homeless/no permanent residence
- ◯ Refused/Unknown
- ◯ Other:

4b. Is homeless or has no permanent residence?

- ◯ Yes
- ◯ No
- ◯ Unknown

5a. Currently has health insurance coverage?

- ◯ Yes
- ◯ No
- ◯ Unknown

5b. Type of health insurance:

(Check all that apply)

- ☐ Medicaid/Medicaid Managed Care
- ☐ Child Health Plus
- ☐ Private Insurance
- ☐ FPEP or FPBP (family planning only)
- ☐ Unknown
- ☐ Other:

5c. Any period of no health insurance coverage since last update?

- ◯ Yes
- ◯ No
- ◯ Unknown

- ○ Out of geographical target area
- ○ Child deceased
- ○ Other: ______

Reproductive History

6a. Been pregnant since last follow-up?

(Exclude pregnancy at program intake)

- ○ Yes
- ○ No
- ○ Unknown

6b. If yes, currently pregnant?

*

- ○ Yes
- ○ No
- ○ Unknown

6c. If so, expected date of delivery:

7a. If not currently pregnant, would like to become pregnant in the next 12 months?

- ○ Yes
- ○ No
- ○ Unknown
- ○ Unsure

7b. If no, have you been consistently using birth control since last follow-up?

- ○ Yes
- ○ No
- ○ Unknown

7c. If yes, types of birth control used since the last follow-up:

(Check all that apply)

- ☐ Abstinence
- ☐ Birth control pill
- ☐ Cervical cap (FemCap)
- ☐ Female condom
- ☐ Spermicide
- ☐ Withdrawal/Other
- ☐ Birth control implant (Implanon/Nexplanon)
- ☐ Birth control vaginal ring (NuvaRing)
- ☐ Condom
- ☐ Emergency contraception (morning after pill)
- ☐ Tubal ligation (female sterilization)
- ☐ Rhythm method/natural family planning/FAM (fertility amenorrhea method)
- ☐ Birth control patch (Ortho Evra)
- ☐ Birth control shot (Depo-Provera)
- ☐ Diaphragm
- ☐ IUD (Mirena, Paragard)
- ☐ Vasectomy (male sterilization)

General Health & Well Being

8. Taking folic acid supplements?

(Or prenatal vitamins, if pregnant)

- ◯ Yes
- ◯ No
- ◯ Unknown

9. Any concerns about a healthy weight?

- ◯ Yes
- ◯ No
- ◯ Unknown

10a. Does potential client use tobacco products or vapes?

- ◯ Yes
- ◯ No
- ◯ Unknown

10b. Does anyone in the household use tobacco productst or vapes?

- ◯ Yes
- ◯ No
- ◯ Unknown

11a. Have they traveled recently (approx. past 3-6 months)?

- ◯ Yes
- ◯ No
- ◯ Unknown

11b. If yes, where?

Currently Pregnant Client

12a. Any prenatal visits?

- ◯ Yes
- ◯ No
- ◯ Unknown

12b. If yes, date of first prenatal visit:

12c. Number of prenatal visits:

13. Plan to feed with breast milk?

- ◯ Yes
- ◯ No
- ◯ Unknown

14a. From whom receives financial support related to pregnancy?

(e.g. buying supplies for the baby; paying for doctors' visits)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

14b. From whom receives social support related to pregnancy?

(e.g. going to doctors' visits, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other:

15. Has physician indicated any concerns about pregnancy weight gain?

- ◯ Yes
- ◯ No
- ◯ Unknown

16a. Has physician indicated any other concerns about pregnancy?

- ◯ Yes
- ◯ No
- ◯ Unknown

16b. If yes, specify physician's concerns:

17. Selected a method of birth control to discuss with physician?

- ◯ Yes
- ◯ No

Client with Children Under Twelve Months

18. Does baby have health insurance?

- ◯ Yes
- ◯ No
- ◯ Unknown

19. Does baby have a primary medical provider?

- ◯ Yes
- ◯ No
- ◯ Unknown

20. Child(ren)'s usual source of medical care:

- ◯ Doctor/clinician's office
- ◯ Hospital outpatient clinic
- ◯ Federally qualified health center (FQHC)
- ◯ Emergency department
- ◯ Urgent care
- ◯ None
- ◯ Unknown
- ◯ Other: ________

21. Currently feeding with breast milk?

- ◯ Breast milk only
- ◯ Breastmilk and formula/solids
- ◯ No

22a. Was child ever fed breast milk?

- ◯ Yes
- ◯ No
- ◯ Unknown

22b. If yes, number of months fed breast milk:

________ Months

22c. Number of months fed only breast milk:

________ Months

23a. From whom receives financial support for self/child?

(e.g. child support payments, buying supplies for the baby; giving cash)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other: ________

23b. From whom receives social support for self/child?

(e.g. child care, transportation, helping with chores)

- ☐ Baby's parent
- ☐ Partner (not baby's parent)
- ☐ Parents
- ☐ Other relatives
- ☐ Friends
- ☐ No one
- ☐ Other: ________

24. In the past 2 weeks, how often was child put to bed:	**Always**	**Usually**	**Sometimes**	**Never**
On Back	◯	◯	◯	◯

24. In the past 2 weeks, how often was child put to bed:	Always	Usually	Sometimes	Never
Alone	○	○	○	○
In Crib	○	○	○	○

Alcohol Use (AUDIT-C)

25. How often do you have a drink containing alcohol?

- ◯ Never (0)
- ◯ Monthly or less (1)
- ◯ 2-4 times a month (2)
- ◯ 2-3 times a week (3)
- ◯ 4 or more times a week (4)

26. How many standard drinks containing alcohol do you have on a typical day?

- ◯ 2 or less (0)
- ◯ 3 or 4 (1)
- ◯ 5 or 6 (2)
- ◯ 7 to 9 (3)
- ◯ 10 or more (4)

27. How often do you have six or more drinks on one occasion?

- ◯ Never (0)
- ◯ Less than monthly (1)
- ◯ Monthly (2)
- ◯ Weekly (3)
- ◯ Daily or almost daily (4)

28. Screening Result?

- ◯ Positive
- ◯ Negative
- ◯ Refused

29. Was client referred?

- ◯ Yes
- ◯ No

30. If another evidence based screening tool was used, what was it?

Substance Use (NIDA)

31. In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol	◯	◯	◯	◯	◯
Tobacco Products	◯	◯	◯	◯	◯
Prescription Drugs for Non-Medical Reasons	◯	◯	◯	◯	◯
Illegal Drugs	◯	◯	◯	◯	◯

32. In your lifetime, which of the following substances have you ever used?

- ☐ Cannabis
- ☐ Cocaine
- ☐ Sedatives or sleeping pills
- ☐ Hallucinogens

33. Screening Result?

- ◯ Positive
- ◯ Negative

34. Was client referred?

- ◯ Yes
- ◯ No

- ☐ Prescription stimulants
- ☐ Methamphetamine
- ☐ Inhalants
- ☐ Street opioids
- ☐ Prescription opioids
- ☐ Other: ______
- ○ Refused

35. If another evidence based screening tool was used, what was it?

______

Domestic Violence (HITS)

36. How often does your partner...?	Not at all *Score 1*	Rarely *Score 2*	Sometimes *Score 3*	Fairly often *Score 4*	Frequently *Score 5*
Physically hurt you	○	○	○	○	○
Talk down to you	○	○	○	○	○
Threaten you with harm	○	○	○	○	○
Scream or curse at you	○	○	○	○	○

37. If any of the above items are not answered, why?

- ○ Does not want to disclose
- ○ Safety concerns
- ○ No partner
- ○ Other:

38. Does CHW have any concerns about violence/coercion in the home not captured by these questions?

- ○ Yes
- ○ No

39. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

40. Was client referred?

- ○ Yes
- ○ No

41. If another evidence based screening tool was used, what was it?

Depression (PHQ-9)

42. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all *Score 0*	Several days *Score 1*	More than half the days *Score 2*	Nearly every day *Score 3*
Little interest or pleasure in doing things	○	○	○	○

42. Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all *Score 0*	Several days *Score 1*	More than half the days *Score 2*	Nearly every day *Score 3*
Feeling down, depressed, or hopeless	○	○	○	○
Trouble falling asleep or staying asleep, or sleeping too much	○	○	○	○
Feeling tired or having little energy	○	○	○	○
Poor appetite or overeating	○	○	○	○
Feeling bad about yourself - or that you are a failure or have let your family down	○	○	○	○
Trouble concentrating on things, such as reading the newspaper or watching TV	○	○	○	○
Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving a lot more than usual	○	○	○	○
Thought that you would be better off dead or of hurting yourself in some way	○	○	○	○

43. If you checked off any of the above items, how difficult have these problems made it for you to work, take care of things at home or get along with other people?

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

44. Screening Result?

- ○ Positive
- ○ Negative
- ○ Refused

45. Was client referred?

- ○ Yes
- ○ No

46. If another evidence based screening tool was used, what was it?

Issues

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Alcohol use	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Substance use	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Physical disability/health problems	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Depression	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Other mental illness/disability	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Domestic violence	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Marital or relationship difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Health concerns for yourself	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Financial difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Unemployment (self or partner)	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Homelessness/inadequate housing	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Legal problems	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Social isolation	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Stress or emotional difficulties	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Inadequate food, clothing, or household items	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Smoking	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Problems with teeth or gums (e.g. pain, bleeding)	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Parenting	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Prenatal/postpartum health issues	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Health concerns for your child	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Concerns about your child's development	◯ Yes ◯ No ◯ Unknown	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

47. Issue...	Currently experiencing?	Would like assistance?	Was information given?	Was client referred?
Accessing dental care	○ Yes ○ No ○ Unknown	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Outreach Event and Group Session Form

Date: *

Start Time:

End Time:

Title:

Workers: (Check all that apply)

☐ Madison, Lara

Location:

Event Type:

If Coordinated Outreach:

Number of partners engaged:

Event Description:

If Group Session:

Number of attendees:

Session Topic:

Contacts

Last Name	First Name	Age (in years)	May Contact?	Preferred Contact
			☐	
			☐	
			☐	
			☐	

Last Name	First Name	Age (in years)	May Contact?	Preferred Contact
			☐	
			☐	
			☐	
			☐	

Referrals

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	
Specify:			◯ Yes ◯ No	

Service Code *	Family Member Referred *	Service Agency	Client Contacted	Date Closed
Specify:			○ Yes ○ No	

* Records missing required fields will not be saved.

Service Codes:

Health Care
1. Adult primary care
2. Child primary care
3. Dental services
4. Early Intervention
5. Family Planning
6. Immunization
7. Lead Testing
8. Mental Health Services
9. Postpartum Care
10. Prenatal Care
11. Other, Specify

Family & Social Support Referrals
12. Breastfeeding
13. Car Seat
14. Childcare
15. Child Development
16. Child Support
17. Clothing / Baby Care Items
18. Domestic Violence
19. Educational Attainment
20. Employment / Vocational Services
21. Environmental Health / Safety
22. English as a Second Langauge (ESL)
23. Family Resource Center
24. Food Pantry
25. Furniture
26. Health Insurance
27. HEAP

Home Visiting
28. Early Head Start
29. Head Start
30. Healthy Families New York
31. Healthy Start
32. Home Instruction for Parents of Preschool Youngsters
33. Nurse-Family Partnership
34. Parent Child Home Program
35. Parents as Teachers
36. Public Health Nurse / LHD
37. Other Home Visiting Program, Specify

Other Services
38. Housing
39. Immigration Services
40. Legal Services
41. Nutrition, General
42. Safe Sleep
43. Smoking Cessation
44. SNAP (Food Stamps)
45. Substance Use
46. Support Groups
47. TANF/DSS Cash Assistance
48. Translation
49. Transportation
50. WIC
51. Other, Specify

Family Member Codes:

1. Client
2. Client's partner
3. Other biological parent of enrolled child (non-partner)
4. Enrolled child
5. Other child
6. Other relative
7. Non-relative

Information

Would like more information about...?

(Check all that apply)

- ☐ Family planning/contraception
- ☐ Pregnancy testing
- ☐ Safe sex
- ☐ Exercise, opportunities to exercise
- ☐ Nutrition, access to healthy foods
- ☐ HIV testing
- ☐ STD testing
- ☐ Job search/placement assistance
- ☐ Adult basic education or GED preparation
- ☐ ESL (English as a Second Language)
- ☐ Vocational or job skills training
- ☐ Alcohol
- ☐ Basic needs (housing, food, etc)
- ☐ Depression
- ☐ Domestic Violence
- ☐ Health Insurance
- ☐ Illicit Drug Use
- ☐ Preventative Care / Primary Care
- ☐ Smoking

Pregnant or Parenting

- ☐ Child care programs
- ☐ Parenting skills
- ☐ Lead assessment/testing
- ☐ Child development
- ☐ Safe sleep
- ☐ Environmental health/safety
- ☐ Car seat use
- ☐ Healthy pregnancy
- ☐ Feeding with breast milk and child nutrition
- ☐ Immunizations
- ☐ Accessing dental care
- ☐ Birth Plan / Preterm Birth
- ☐ Infant / New Born Care
- ☐ Postpartum Care
- ☐ Prental Care

Training Form

Date: *

Training Type:

Topic:

Workers: (Check all that apply)

- [ ] Madison, Lara